Keystone Point of Service

TYPE OR PRINT

REMEMBER TO AVOID DELAYS, BE SURE ITEM 9, EMPLOYEE'S SOCIAL SECURITY # IS PROVIDED

INFORMATION WE NEED FROM YOU

SECTION A

I am choosing to receive covered healthcare services for myself or a dependent outside of the designated referral system. I understand that by using self-referred products, I will be subject to a deductible, coinsurance and other co-payments, as specified in the contract.

SIGNED - EMPLOYEE OR SPOUSE	DATE	THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED.
✗		

SECTION B

1. PATIENT'S NAME (FIRST, M.I., LAST)				ID#
2. PATIENT'S ADDRESS (IF DIFFERENT FROM EMPLOYEE)	STREET			
	CITY	STATE / ZIP CODE	HOME TELEPHONE NO.	BUSINESS TELEPHONE NO.
3. PATIENT'S DATE OF BIRTH (MONTH/DAY/YEAR)	4. PATIENT'S SEX ☐ M ☐ F	5. PATIENT'S RELATION TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		
6. SUBSCRIBER'S NAME (FIRST, M.I., LAST)				ID#
7. SUBSCRIBER'S ADDRESS AND TELEPHONE NO.	STREET			
	CITY	STATE / ZIP CODE	HOME TELEPHONE NO.	BUSINESS TELEPHONE NO.

8. WAS CONDITION RELATED TO:	A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO	B. AN ACCIDENT ☐ YES ☐ NO	IF AN ACCIDENT	DATE	TIME ☐ AM ☐ PM	DESCRIPTION (HOW AND WHERE)

9. SUBSCRIBER'S SOCIAL SECURITY NUMBER	10. GROUP NAME (EMPLOYER'S COMPANY NAME)

11. IS PATIENT COVERED BY ANY OTHER HEALTH PLAN? ☐ YES ☐ NO	IF YES	NAME OF POLICYHOLDER / POLICY NUMBER	NAME AND ADDRESS OF INSURANCE COMPANY

12. IS PATIENT COVERED BY MEDICARE? ☐ YES ☐ NO	13. IS CHILD FULL-TIME STUDENT? ☐ YES ☐ NO	*I authorize the release of any information necessary to process this request.*
		14. SIGNED (PATIENT OR PARENT IF MINOR) ✗

INFORMATION TO BE COMPLETED BY PHYSICIAN

SECTION C

15. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	16. DATE FIRST CONSULTED YOU FOR THIS CONDITION

17. DIAGNOSIS, OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO #S 1,2,3 ETC. OR DX CODE

18. A. PLACE OF SERVICE	B. DATE OF SERVICE	C. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES, OR SUPPLIES FOR EACH DATE: PROCEDURE CODE	MOD1	MOD2	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	D. DIAGNOSIS CODE OR UNITS	E. CHARGES

19. YOUR PATIENT'S ACCOUNT NO.	20. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER	22. TOTAL CHARGES
21. ENTER THE TAXPAYER ID NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED BY LAW TO FURNISH YOUR TAXPAYER ID NUMBER.		23. AMOUNT PAID
		24. BALANCE DUE

TAXPAYER ID NO.	25. SIGNATURE OF PHYSICIAN OR SUPPLIER	DATE

26. SIGNED (PATIENT OR PARENT IF MINOR)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact, material thereto commits a fraudulent insurance act, which is a crime and subjects such persons to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which claim is being made were necessary and were, in fact, furnished.

- *For participants in ERISA, self-funded products, references to subscriber/member shall include participants, and payments for covered services will be made by Keystone Health Systems on behalf of the employer group.*
- *Independence Blue Cross offers products directly through its subsidiaries Keystone Health Plan East and QCC Ins. Co., and with Highmark Blue Shield. Independent Licensees of the Blue Cross and Blue Shield Association.*

EMPLOYEE

1. **EACH TIME YOU REQUEST BENEFITS, SIGN SECTION A AND COMPLETE SECTION B (ITEMS 1 - 14) ON THE REVERSE SIDE OF THIS FORM.**

   USE A SEPARATE BENEFIT REQUEST FORM FOR EACH MEMBER OF THE FAMILY.

2. **ASK YOUR DOCTOR, HOSPITAL OR SUPPLIER TO COMPLETE SECTION C (THE PHYSICIAN OR SUPPLIER INFORMATION: ITEMS 15 - 25) OR ATTACH ITEMIZED BILLS.**

   ITEMIZED BILLS SHOULD INCLUDE:

   - ✔ **DOCTOR'S NAME & ADDRESS**
   - ✔ **PATIENT'S NAME**
   - ✔ **DATE OF SERVICE**
   - ✔ **CONDITION BEING TREATED/DIAGNOSIS**
   - ✔ **CHARGE FOR SERVICE**
   - ✔ **TYPE OF SERVICE**

SEND THIS REQUEST FOR BENEFITS TO
CLAIMS SERVICING CENTER
PO BOX 7458
PHILADELPHIA, PA 19101-7458

IF YOU HAVE ANY QUESTIONS, CALL
215-567-3550 OR
800-253-3854
OUTSIDE OF PHILADELPHIA

DOCTOR, HOSPITAL OR SUPPLIER

1. **COMPLETE ITEMS 15 - 25 ON THE BENEFITS REQUEST FORM USING CURRENT CPT PROCEDURE AND ICD-9-CM DIAGNOSIS CODES.**

2-DIGIT PLACE OF SERVICE CODES
(THE CURRENT 2-DIGIT PLACE OF SERVICE CODE MUST BE USED ON ALL CLAIM SUBMISSIONS)

11	OFFICE
12	HOME
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
23	EMERGENCY ROOM (HOSPITAL)
24	AMBULATORY SURGICAL CENTER (ASC)
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
31	SKILLED NURSING FACILITY (SNF)
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
34	HOSPICE
41	AMBULANCE (LAND)
42	AMBULANCE (AIR OR WATER)
51	INPATIENT PSYCHIATRIC FACILITY
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
61	COMPREHENSIVE INPATIENT REHAB FACILITY
62	COMPREHENSIVE OUTPATIENT REHAB FACILITY
65	END STAGE RENAL DISEASE TREATMENT CENTER
71	STATE OR LOCAL PUBLIC HEALTH CENTER
72	RURAL HEALTH CLINIC
81	INDEPENDENT LABORATORY
99	OTHER UNLISTED FACILITY